MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10913

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VSA 15

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown RR

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: Hagerstown R 2

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 20 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown RR Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Hagerstown R 2

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Adam Kirk Barnhart

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 27, 1914

8. AGE:

Years	Months	Days	If less than one day
26	1	21	hrs. min.

9. Birthplace: Greencastle Pa.

(Town, county, and state)

10. Usual occupation: Student

11. Industry or business

FATHER — 12. Name: Harry A. Barnhart.

13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: Ella. Burger.

15. Birthplace: Pennsylvania

16. Informant: Harry A Barnhart.

Address: Hagerstown R 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 22, 1940 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Greencastle, Pa.

18. Funeral director: Jacob A. Teeter

Address: Greencastle, Pa.

19. Oct. 22 1940 (Date rec'd by registrar) Janet M. Foltz Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 18 1940, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1940, to Oct 18 1940, and that I last saw him alive on Oct 18 1940.

	DURATION
Immediate cause of death: Myocardial Dilitation	10/18/40
Myocarditis Chr	?
Due to	
Due to	
Other conditions: epilepsy	9/1/39

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H S Porterfield M D (M. D. or other)

Address: 136 W Washington St Date signed: 10/20/40

CEIVED
NOV 6 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (13-a)

Reg. Dist. No. 304

CERTIFICATE OF DEATH

10914

1. PLACE OF DEATH:

(a) County Washington

(b) City or town Hancock.
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 8 Years

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County Washington

(c) City or town Hancock.
(If outside city or town limits, write RURAL and give town)

(d) Street No.
(If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** Raymond Stanley Barr

3 (b) If veteran, name war

3 (c) Social Security No. 217-05-2265

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Esther Barr

6. (c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.) Oct. 12 1908

8. AGE: Years	Months	Days	If less than one day
32	0	2	____hr. ____min.

9. Birthplace Washington Co.
(Town, county, and state)

10. Usual occupation Motion Picture Operator

11. Industry or business

FATHER
12. Name John Barr
13. Birthplace Washington Co.

MOTHER
14. Maiden Name Blanch Miller
15. Birthplace Washington Co.

16 (a) Informant Esther Barr
(b) Address Hancock, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 17 1940 (month) (day) (year)

(c) Cemetery or crematory St. Pauls
Location Western Pike Near Clearspring

18 (a) Funeral director Snyder-Rowland
(b) Address Hancock, Md.

19 (a) 10/16 40 (Date rec'd by registrar) (b) J P Jenkins Registrar

MEDICAL CERTIFICATION

20. Date of death Oct. 14 1940, at 6:20 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/7/40 19__ to 10/13 1940, and that I last saw him alive on 10/7/40 19__.

Immediate cause of death	Duration
acute myocarditis	
Due to	
Due to	
Other conditions Deformity of Chest	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E M Shaffer M.D. (M. D. or other)

Address Hancock Date signed 10/15/40

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 6 1940

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

10915

Reg. Dist. No. 350

1. PLACE OF DEATH:
County: Washington County
City or town: Ferry Hill Sharpsburg Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 1 yrs ago

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Ferry Hill Sharpsburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Sharpsburg Maryland
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: Mexican War

3. (a) FULL NAME (Captain John Kyd Beckenbaugh

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Harriet Louisa Howard Beckenbaugh — 6(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): Jan 14 1874

8. AGE: Years	Months	Days	If less than one day
66	9	21	2 hrs. ___ min.

9. Birthplace: Hagerstown, Md
(Town, county, and state)
10. Usual occupation: Supt of Antietam National Battlefield
11. Industry or business:

FATHER
12. Name: John M Beckenbaugh
13. Birthplace: Hagerstown, Md

MOTHER
14. Maiden name: Mannie Cowen
15. Birthplace: Fairmeill near Sharpsburg

16. Informant: Harriet Louisa Beckenbaugh
Address: Ferry Hill Sharpsburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 8 1940 (month) (day) (year)
Cemetery or crematory: Elmwood Cemetery
Location: Shepherdstown, Md
16. Funeral director: Edith V Leaf
Address: Williamsport, Md

19 10-8 1940 (Date rec'd by registrar) Carl Boyer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5 1940, at 7:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 29 1940 to Oct 5 1940 and that I last saw h alive on Oct 5, 1940

Immediate cause of death	DURATION
Coronary Thrombosis.	6 days.
Infarct of right Ventr.	3 days.
Due to Arteriosclerosis of Coronary	
Due to arteriosclerosis.	1 year.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Walter H. Sheely M.D.
M. D. or other
Address Sharpsburg, Md Date signed 10/7/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

CEIVED
NOV 5 1940
...EAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10916

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years

Hospital, institution, or street address where death occurred:

302 Jefferson Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 302 Jefferson Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Annie M. Brandenburg

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Elmer C. Brandenburg

6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Feby. 24, 1873

8. AGE:

Years	Months	Days	If less than one day
67	8	5	hrs. min.

9. Birthplace: Washington County, Md.
(Town, county, and state)

10. Usual occupation: Home Duties

11. Industry or business

FATHER

12. Name: David Bachtell

13. Birthplace: Washington County, Md.

MOTHER

14. Maiden name: Mary Elizabeth Eakle

15. Birthplace: Washington County, Md.

16. Informant: Elmer C. Brandenburg

Address: Hagerstown, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 1, 1940 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. 10/31/1940 (Date rec'd by registrar) Ghost Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 29, 1940 4:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death

	DURATION
Chr. Myocarditis	1935
Due to: Acute ventricular dilatation	10/29/40
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: no

Date of op.

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: D. Robertshello DEPUTY MEDICAL EXAM. WASH. CO., MD.

Address: Hagerstown, Md. M. D. practice

Date signed: 10/30/40

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10917

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, Institution, or street address where death occurred:
934 Hamilton Blvd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: New York County: Queens

City or town: Laurelton L. I.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 130-08 227 Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Kate Bressler

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Lewis Bressler

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 23, 1878

8. AGE: Years	Months	Days	If less than one day
62	5	3	..... hrs. ..... min.

9. Birthplace: Poland
(Town, county, and state)

10. Usual occupation: Home Work

11. Industry or business

FATHER — 12. Name: Joseph Cohen

FATHER — 13. Birthplace: Poland

MOTHER — 14. Maiden name: Sora Cohen

MOTHER — 15. Birthplace: Poland

16. Informant: Albert A. Bressler

Address: 130-08 227 St. Laurelton, N. Y.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 28 1940 (month) (day) (year)

Cemetery or crematory: Washington Cemetery

Location: Brooklyn City, N. Y.

18. Funeral director: Fred W. Kraiss,

Address: Hagerstown, Maryland.

19. Oct 29, 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 26th 1940, at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 23 1940, to Oct 26th 1940

and that I last saw h[illegible] alive on Oct 23rd 1940

Immediate cause of death	DURATION
Coronary occlusion	Sudden
Due to	
Due to	
Other conditions: Gall Bladder Disease (Include pregnancy within 3 months of death)	3-4 yrs.

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Chas J Hellman MD

M. D.

Address: 159 W. Washington St Hagerstown Md Date signed 10/27/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 6 1940
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-F

CERTIFICATE OF DEATH

10918

Reg. Diat. No. 303

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 weeks.

Hospital, institution, or street address where death occurred:

325 Liberty St.

How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 325 Liberty St

(If rural, give LOCATION)

2.(a) If veteran, name war none

3. (a) FULL NAME Herbert McKinley Burkett.

3. (b) Social Security Number 219-05-2826

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife Nora Colvin-

6.(c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) March 12 - 1902

8. AGE: Years 38 | Months 7 | Days 3 | If less than one day ____ hrs. ____ min.

9. Birthplace Luray Page Co Va.

(Town, county, and state)

10. Usual occupation Laborer.

11. Industry or business

FATHER 12. Name Thos Lee Burkett

13. Birthplace Luray Va.

MOTHER 14. Maiden name Virginia Breeden.

15. Birthplace Luray Va.

16. Informant Mrs Nina Burkett.

Address Hagerstown. Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof Oct 17-1940 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown. Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Oct 17. 40 (Date rec'd by registrar) Chas Hoover Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1940, at 6 LOA M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 15 1940 to Oct 15 1940 and that I last saw h[illegible] alive on Oct 15 1940

Immediate cause of death	DURATION
Tuberculosis of lungs	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Beachley M. D. or other

Address Hagerstown, md Date signed 10-17-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Beachley.

NOV 6 1940
BUREAU V. S.

10919

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 73
Hospital, institution, or street address where death occurred:
57 W. Franklin
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 57 W. Franklin
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Carrie Barr Clarkson

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife: John T. Clarkson
6.(c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.): Oct 3 - 1867

8. AGE:

Years	Months	Days	If less than one day
73	-	13	hrs. min.

9. Birthplace: Hagerstown, Wash. Co. Md.
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: own home
FATHER 12. Name: John T. Barr
13. Birthplace: Hagerstown, Md.
MOTHER 14. Maiden name: Elizabeth Faulder
15. Birthplace: Beaver Creek, Md
16. Informant: Mrs. John Talbot
Address: Funkstown, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 18-1940 (month) (day) (year)
Cemetery or ~~Crematory~~: Rose Hill
Location: Hagerstown, Md.
18. Funeral director: C. M. Suter & Sons.
Address: Hagerstown, Md
19. Oct 17 40 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 16 1940, at 3:40 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1940, to Oct 16, 1940
and that I last saw her alive on Oct 15 1940

Immediate cause of death	DURATION
Cerebral Hemorrhage - Cerebral Thrombosis	
Due to: Arteriosclerosis	
Due to: Diabetes Mellitus	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: A. P. Stanton M. D. or other
Address: Hagerstown Date signed: Oct 16, 40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 6 1940
BUREAU, V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92E)

CERTIFICATE OF DEATH

10920

Reg. Dist. No. 302

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred:
Washington County Home
How long in hospital or institution? 1 year

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Washington County Home
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William R. Colvin

3.(b) Social Security Number: None

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Leva Colvin
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): October 30, 1868

8. AGE: Years: 71 | Months: 11 | Days: 17 | If less than one day: ...hrs. ...min.

9. Birthplace: Page County, Virginia (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Thomas Colvin
13. Birthplace: Rappahannock Co., Va.

MOTHER
14. Maiden name: Sarah McCollister
15. Birthplace: Rappahannock Co., Va.

16. Informant: Mrs. Leva Colvin
Address: Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 19, 1940 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss
Address: Hagerstown, Md.

19. Oct 19 1940 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 17, 1940, 9:00 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 7 19 40 to Oct 17 19 40
and that I last saw h... alive on Oct. 17 19 40

Immediate cause of death: Chronic Myocarditis — DURATION 1 yr.
Due to:
Due to:
Other conditions: Senile Senescence
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J H Bradley M. D. or other
Address: Hagerstown, Md. Date signed: 10/21/40

RECEIVED
NOV 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10921

Reg. Dist. No. 307

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 das.
Hospital, institution, or street address where death occurred: Wash. Co. Hospital.
How long in hospital or institution? 3 das.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State West Virginia County Jefferson
City or town Charlestown
(If outside city or town limits, write RURAL and give nearest town)
Street No. none
(If rural, give LOCATION)
2.(a) If veteran, name war none

3.(a) FULL NAME Nancy Elizabeth Comer.

3.(b) Social Security Number none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single.

6.(b) Name of husband or wife none
6.(c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) March 5- 1940

8. AGE: Years	Months	Days	If less than one day
—	6	27.	..... hrs. ..... min.

9. Birthplace Charlestown Jefferson Co. W. Va. (Town, county, and state)
10. Usual occupation none
11. Industry or business ——.

FATHER
12. Name Luther W. Comer.
13. Birthplace Charlestown. W. Va.

MOTHER
14. Maiden name Alice Nice Warner.
15. Birthplace Charlestown. W. Va

18. Informant Melvin Strider
Address Charlestown. W. Va.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof Oct 3-1940 (month) (day) (year)
Cemetery or crematory Edge Hill Cemetery
Location Charlestown W. Va

18. Funeral director Andrew K. Coffman
Address Hagerstown Md

19. Oct 1, 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1. 1940 at 7:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 29 1940, to Oct 1 1940
and that I last saw h[illegible] alive on Oct 1 1940

Immediate cause of death	DURATION
Encephalatis	one day
Due to Pertussis	
Due to	
Other conditions Tetany	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results Gross as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury Injured at work?

23. SIGNATURE J. L. D. Bowman M. D. or other
Address Hagerstown, Md. Date signed Oct 1/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Bowman

RECEIVED
NOV 6 1940
BUREAU OF STANDARDS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

10922

Reg. Dist. No. 302

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Washington Co.
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mo
Hospital, Institution, or street address where death occurred:
42 East Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 42 East ave
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME JENNIE E CONNER

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	S

6.(b) Name of husband or wife — — —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 8-16-53

8. AGE: Years	Months	Days	If less than one day
87	2	5	..... hrs. ..... min.

9. Birthplace Cumberland Co Pa (Town, county, and state)

10. Usual occupation Retired School Teacher

11. Industry or business

FATHER
12. Name MOSES CONNER
13. Birthplace PA

MOTHER
14. Maiden name SARAH RUTH
15. Birthplace Pa

16. Informant Vernon B. McClure
Address 42 East Ave Hagerstown Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-24-40 (month) (day) (year)
Cemetery or crematory Old Grace Yard
Location Carlisle Pa

18. Funeral director J. C. Lutz & Son
Address Carlisle, Pa.

19. Oct 23, 1940 (Date rec'd by registrar) Floyd H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 19 40 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10 19 40 to Oct 20 19 40 and that I last saw h... alive on Oct 18 19 ....

Immediate cause of death	DURATION
Uraemia ; due to a.	
b. Senile advanced senility, C.M.&S.R.	
Due to Senile senility	
Due to	
Other conditions Bronchopneumonia	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. H. Curtis M.D.
M. D. or other
Address 134 N. Potomac Date signed 10-21-40

RECEIVED
NOV 6 1940
BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

10923

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs.

Hospital, institution, or street address where death occurred:
466 So Cannon Ave.

How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 466 So. Cannon Ave
(If rural, give LOCATION)

2.(a) If veteran, name war no

3. (a) FULL NAME
Mrs Sarah Margaret De Losier.

3. (b) Social Security Number
none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Harry W.

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 26-1881.

8. AGE: Years	Months	Days	If less than one day
59	—	15	hrs. min.

9. Birthplace Hancock Wash. Co Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business —

FATHER
12. Name Joseph Wolfel.
13. Birthplace Berlin Germany.

MOTHER
14. Maiden name Rena Hagen.
15. Birthplace Berlin Germany.

18. Informant Miss Opal. De Losier.
Address Hagerstown. Md

17. Burial. Date thereof Oct 12-1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Hagerstown. Md

18. Funeral director Andrew K. Coffman
Address Hagerstown. Md.

19. Oct. 12 1940 Chas H Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10 1940 at 10 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct — 1939, to Oct 10 1940 and that I last saw her alive on Oct 6-1940 19

Immediate cause of death	DURATION
Uremia	1 day
Due to Chr. Nephritis	2 mos
Due to Diabetic Gangrene both feet	3 mos
Other conditions Diabetes	not known

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following.

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Hagerstown Md Date signed 10/12/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr H R. Kritzer.

RECEIVED
NOV 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

Reg. Dist. No. 10924 3053

1. PLACE OF DEATH:

County Washington

City or town Hagerstown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mos.

Hospital, Institution, or street address where death occurred: 514 Oak Hill Ave

How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Washington

City or town Sharpsburg (If outside city or town limits, write RURAL and give nearest town)

Street No. main St (If rural, give LOCATION)

2.(a) If veteran, name war no

3. (a) FULL NAME Mrs Anna M. Dorsey

3. (b) Social Security Number none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow.

6.(b) Name of husband or wife Chas. Christian

6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) August 4 - 1856

8. AGE: Years	Months	Days	If less than one day
84	2	9.	...hrs. ...min.

9. Birthplace Sharpsburg Washington Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business ———

FATHER 12. Name Jacob Stine

13. Birthplace Mercersburg, Pa.

MOTHER 14. Maiden name Maria Thomas

15. Birthplace Sharpsburg Md.

16. Informant Mrs. J. C. Grice

Address Hagerstown Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof Oct 15-1940 (month) (day) (year)

Cemetery or crematory Mt. View Cemetery

Location Sharpsburg Md.

18. Funeral director Andrew K. Cossman

Address Hagerstown Md

19. October 14 1940 (Date rec'd by registrar) Chas. H. Beavers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1940 at 12 20 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 9-30 1940 to 10-13 1940

and that I last saw h... alive on 10-13 1940

Immediate cause of death	DURATION
Bronchopneumonia	11 days.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE John H. Hornbaker M. D. or other

Address 158 W. Washington St Date signed 10-14-40

Hagerstown, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-415

Dr. Hornbaker.

RECEIVED
NOV 6 1949
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

10925

CERTIFICATE OF DEATH

Reg. Dist. No. 306

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Washington

City or town Smithsburg md # 2

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Washington

City or town Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Harriett Virginia Duffey

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Samuel H. Duffey

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31 1870

8. AGE:

Years	Months	Days	If less than one day
70	6	1	hrs. min.

9. Birthplace Friends creek md (Town, county, and state)

10. Usual occupation House Work

11. Industry or business

FATHER

12. Name Jacob Turner

13. Birthplace Frederick Co Md

MOTHER

14. Maiden name Catherine Schuyler

15. Birthplace Frederick Co Md

16. Informant Mrs Harry Ferguson

Address Smithsburg md # 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/6 1940 (month) (day) (year)

Cemetery or crematory Friends Creek

Location Near Emmitsburg Md

18. Funeral director Walter J Grove

Address Waynesboro Pa

19. Oct 5 1940 (Date rec'd by registrar) Geo. W. Ferguson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3 1940, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1940, to Oct 3 1940, and that I last saw h alive on Oct 3 1940.

Immediate cause of death	DURATION
Mesenteric Thrombosis	3 hrs
Due to Arterio Sclerosis	4 yrs
Due to Chronic Myocarditis	3 yrs
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE G. H. Hobler M. D. or other

Address Emmitsburg Date signed 10/4/40

RECEIVED
OCT 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

10926

Reg. Diat. No. .....

1. PLACE OF DEATH:

County Washington

City or town Hagerstown.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs.

Hospital, Institution, or street address where death occurred:

31 W. Franklin St.

How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 31 W. Franklin St

(If rural, give LOCATION)

2.(a) If veteran, name war none

3.(a) FULL NAME Mrs Frances Gertrude Fahrney

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife Walter S.

6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Oct 31 - 1876

8. AGE: Years	Months	Days	If less than one day
63	11	23	....hrs. ....min.

8. Birthplace Williamsport. Washington Co Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business own home.

FATHER 12. Name Peter Coffman.

FATHER 13. Birthplace Shepherdstown. Md.

MOTHER 14. Maiden name Catherine Zittle

MOTHER 15. Birthplace Boonsboro Md.

16. Informant Francis E. Fahrney

Address Hagerstown. Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof Oct 25-1940 (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md

19 October 25 1940 Margaret B. Bowers Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1940 at 12.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-22-40 19.. to 10-23-40 19.. and that I last saw h.. alive on 10-23-40 19..

Immediate cause of death	DURATION
Congestive Heart failure	1 yr
Due to Hypertension, Heart Disease	2 yr
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Hagerstown Md Date signed 10-25-40

Deputy

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Or Young.

RECEIVED
NOV 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (S)

Reg. Dist. No. 303

10927

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Washington
(b) City or town Clear Spring Rural
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Washington
(c) City or town Clear Spring Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Baby Farrow

3 (b) If veteran, name war

(c) Social Security No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			hr. min.

9. Birthplace Washington Co.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Carl Farrow
13. Birthplace Washington Co

MOTHER
14. Maiden Name Margret Bowers
15. Birthplace Franklin Co. Pa

16 (a) Informant Carl Farrow
(b) Address Clear Spring Rural

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 2 1940 (month) (day) (year)
(c) Cemetery or crematory St Pauls
Location Near Clear Spring

18 (a) Funeral director Snyder Rowland
(b) Address Clear Spring Md.

19 (a) Oct 2-1940 (Date rec'd by registrar) (b) Joseph W. Murray Registrar

MEDICAL CERTIFICATION

20. Date of death Oct 1, 1940, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1, 1940, to Oct 1, 1940 and that I last saw him alive on 19.

Immediate cause of death	Duration
Stillborn	
Due to Premature separation of Placenta	2 days.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David R. Brewer M.D.
M. D. or other
Address Clear Spring Md Date signed Oct 2, 1940

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

10928

Reg. Diat. No. 307

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Washington
City or town: Gapland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death: Life.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Infant Fellows

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single.

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			hrs. min.

9. Birthplace: Gapland (Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: Charles Reynolds Fellows.
13. Birthplace: West Virginia.
MOTHER 14. Maiden name: Margaret Virginia Mornington
15. Birthplace: West Virginia.
16. Informant:
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 23 1940 (month) (day) (year)
Cemetery or crematory: Mt. Zion
Location: Keedysville near Hagerstown, Md.
18. Funeral director: Wm. D. Bast & Son
Address: Boonsboro Md.
19. Oct 23 1940 (Date rec'd by registrar) Mrs Katherine Degenhart Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 21, 1940 at 3 00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 21 1940, to October 21 1940 and that I last saw him alive on October 21 1940

Immediate cause of death	DURATION
Stillborn.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: G. W. Lehan M. D.
M. D. or other
Address: Boonsboro, Md. Date signed Oct. 22, 1940

RECEIVED
NOV 6 1940

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (112)

10929

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or ~~town~~: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, ~~institution~~, or ~~street address~~ where death occurred: Washington Co

How long in hospital or institution? 4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or ~~town~~: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1100 Woodland Way
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Terence Galligan

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Jan 2 - 1934

8. AGE:

Years	Months	Days	If less than one day
6	10	14	hrs. min.

9. Birthplace: Piedmont, California
(Town, county, and state)

10. Usual occupation: at Home

11. Industry or business:

FATHER
12. Name: F. A. Galligan
13. Birthplace: Wisconsin

MOTHER
14. Maiden name: Mary Benham Bizard
15. Birthplace: Chicago, Ill.

16. Informant: F. A. Galligan
Address: Hagerstown, Md

17. Cremation (Burial, cremation, or removal, Which?) Date thereof: Oct 17-1940 (month) (day) (year)

~~Cemetery~~ or crematory: Cedar Hill

Location: Washington, D. C.

18. Funeral director: C. M. Suter & Sons
Address: Hagerstown, Md.

19. October 17 1940 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 16 1940, at 3:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 14 1936, to Oct 16 1940 and that I last saw him alive on Oct. 16 1940

Immediate cause of death	DURATION
Acute Cardiac Failure & Circulatory Collapse	6 hours
Due to: Chronic Bronchial Asthma	6 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: Not reported.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. Edwin Blair M. D. ~~or other~~

Address: 214 N. Potomac St. Date signed: Oct. 16-40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1940
BUREAU V. S.

VS A15 (T) (I) MARGIN RESERVED FOR BINDING (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77-c)

10930

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Oct. 19'40

Hospital, institution, or street address where death occurred: On Startzman farm between Pa. & W. M. R. R. at Halfway, Md.

How long in hospital or institution? none.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 437 Guilford Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Jacob A. Gearhart

3. (b) Social Security Number 705-10-4728.

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married.

6.(b) Name of husband or wife: Ruth Helen.

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): June 9 - 1882

8. AGE: Years 58 | Months 4 | Days 25 | If less than one day ... hrs. ... min.

9. Birthplace: Big Pool Wash. Co Md.
(Town, county, and state)

10. Usual occupation: Car Inspector

11. Industry or business: W. Md R.R.

FATHER
12. Name: Jacob Gearhart
13. Birthplace: Big Pool Md.

MOTHER
14. Maiden name: Rachael A Myers.
15. Birthplace: Big Pool Md.

16. Informant: Mrs E W. Barnhart
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 5 40 (month) (day) (year)

Cemetery or crematory: Rest Haven Cem

Location: Hagerstown. Md

18. Funeral director: Andrew K Coffman
Address: Hagerstown. Md.

19. November 4 1940 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19, 1940 at 8P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw him alive on ... 19...

Immediate cause of death: Acute alcoholism — DURATION: 10/19-40

Due to: Exposure

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: no
Date of op.

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: S. Robert Wells DEPUTY MEDICAL EXAM WASH. CO., MD. M. D. or other

Address: Hagerstown, Md. Date signed: 11/4/40

RECEIVED
DEC 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

10931

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Wolfinger

1. PLACE OF DEATH:
County Washington.
City or town near Cheneyville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 36 yrs.
Hospital, Institution, or street address where death occurred:
Hagerstown R# 5
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town near Cheneyville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Hagerstown R# 5
(If rural, give LOCATION)
2.(a) If veteran, name war no

3.(a) FULL NAME Mrs Anne R. Good.

3.(b) Social Security Number none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White.	Married.

6.(b) Name of husband or wife Theadore
6.(c) If alive, give age 72 years
7. Birth date of deceased (mo., day, yr.) June 30 - 1871.

8. AGE: Years	Months	Days	If less than one day
69	3	25	hrs. min.

9. Birthplace Greencastle Franklin Co. Pa. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business own home.
FATHER 12. Name Jacob Bowers
13. Birthplace Maugansville Md.
MOTHER 14. Maiden name Sarah Zimmerman
15. Birthplace Welsh Run Pa.
16. Informant Theadore Good
Address Hagerstown Md R# 5.
17. Burial. (Burial, cremation, or removal. Which?) Date thereof Oct 27-1940 (month) (day) (year)
Cemetery or crematory Broadfording Cemetery
Location Broadfording, Md.
18. Funeral director Andrew K. Coffman
Address Hagerstown, Md.
19. Oct. 26, 1940 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1940, at 11. P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1 1940, to Oct 24 1940
and that I last saw h. m. alive on October 24 1940

Immediate cause of death	DURATION
Cerebral Thrombosis	
Due to	
Due to	
Other conditions Chronic myocarditis Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Walter L. Wolfinger M. D. or other
Address Smithsburg, Md. Date signed Oct 25, 1940

RECEIVED
NOV 6 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

10932

B1-a

1. PLACE OF DEATH

County Washington Registration Dist. No. 301

Village or City Near Williamsport No. R.R. 1 St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Elizabeth Marie Gray

(a) Residence: No. Williamsport R. 1 St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F.	col.	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, and year) May 6, 1926

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	5	7	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. None

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Williamsport, Md. R D 1
(State or country) Maryland

FATHER

13. NAME John P. Gray

14. BIRTHPLACE (city or town) Hagerstown
(State or country) Maryland

MOTHER

15. MAIDEN NAME Sylvia Stepp

16. BIRTHPLACE (city or town) Shenandoah
(State or country) Virginia

17. INFORMANT John P. Gray
(Address) Williamsport, Md. R D 1

18. BURIAL, CREMATION, OR REMOVAL
Place Hagerstown Date Oct. 15, 1940
Rose Hill Cemetery

19. UNDERTAKER Fred W. Kraiss,
(Address) Hagerstown, Md.

20. FILED Oct 15-40 Mrs E Lee McElroy
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Oct. (Month) 13 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1940, to Oct. 15, 1940

I last saw h[illegible] alive on Oct. 12, 1940; death is said to have occurred on the date stated above, at 8-15 A.m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Child has been an imbecile since birth. During last week a meningeal involvement developed.	11-1-40.
Other **Contributory Causes** of importance:	

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) [signature] M. D.

(Address) Williamsport Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

Reg. Dist. No. 10933 303

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Washington

City or ~~Town~~ Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs.

Hospital, institution, or street address where death occurred:

Washington County

How long in hospital or institution? Dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or ~~Town~~ Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 252 Hager

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Jesse W. Griffey

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of husband or wife Charlotte Griffey

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 12- 1866

8. AGE:

Years	Months	Days	If less than one day
74	8	29	...hrs. ...min.

9. Birthplace Cumberland Alleghany Co, Md

(Town, county, and state)

10. Usual occupation Retired Train Despatcher

11. Industry or business W-M. R. R. Co.

FATHER 12. Name George Griffey

13. Birthplace not Known.

MOTHER 14. Maiden name Catherine Miller

15. Birthplace not Known

16. Informant Miss Flora Griffey

Address Hagerstown, Md

17. Burial Date thereof Oct 13-1940

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or ~~crematory~~ High Wood

Location Pittsburgh, Pa.

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Md.

19. Oct 14 1940 Clark Bowers

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, 1940 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw him alive on ...19...

Immediate cause of death Chronic myocarditis — DURATION 1939

Angina Pectoris — 1939

Due to ...

Due to ...

Other conditions ...

(Include pregnancy within 3 months of death)

Major findings of operations None

...Date of op. ...

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of ...

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) No

Means of injury Injured at work?

23. SIGNATURE J. Robert Wells DEPUTY MEDICAL EXAM. WASH. CO., MD.

M. D. number

Address Hagerstown, Md. Date signed 10/12/40

RECEIVED
NOV 6 1940
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

10934

Reg. Diat. No. 307

VS A15 (T) PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. (I) MARGIN RESERVED FOR BINDING (M)

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 years
Hospital, Institution, or street address where death occurred: W. Bethel St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: W Bethel St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Rena Harris

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Not Known

8. AGE: Years	Months	Days	If less than one day
about 70			hrs. min.

9. Birthplace: Atlanta Ga (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business:

FATHER
12. Name: unknown
13. Birthplace:

MOTHER
14. Maiden name: unknown
15. Birthplace:

16. Informant: Rev C. C. Comer
Address: 374 W Bethel
17. Burial, cremation, or removal. Which? Burial Date thereof: Nov 2-40 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown
18. Funeral director: Jm Caldwell
Address: Hagerstown Md
19. Nov 1, 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 31 1940, at 2:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 11 1940 to Oct 31 1940
and that I last saw h-r alive on Oct 27 1940

Immediate cause of death	DURATION
Cerebral Hemorrhage	16 days
Due to	
Due to	
Other conditions: Arteriosclerosis	?

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Hagerstown Md Date signed: 11/1/40

RECEIVED
DEC 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-R)

10935

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown R# 5 — (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr.

Hospital, Institution, or street address where death occurred: Fiddlersburg Rd.

How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Washington

City or town near Hagerstown (If outside city or town limits, write RURAL and give nearest town)

Street No. Fiddlersburg Rd. (If rural, give LOCATION)

2.(a) If veteran, name war no

3. (a) FULL NAME Shirley Delores Henson.

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single.

6.(b) Name of husband or wife none

6.(c) If alive, give age —. years

7. Birth date of deceased (mo., day, yr.) July 24 - 1935

8. AGE: Years	Months	Days	If less than one day
5	2	12.	..... hrs. ..... min.

9. Birthplace Hagerstown Wash. Co. Md. (Town, county, and state)

10. Usual occupation at home

11. Industry or business —.

FATHER 12. Name Robert N. Henson.

13. Birthplace Hagerstown Md.

MOTHER 14. Maiden name Nellie E Hatfield.

15. Birthplace Union Bridge Md.

16. Informant Robert N Henson.

Address Hagerstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 7 - 1940 (month) (day) (year)

Cemetery or crematory Rest Haven Cem.

Location Hagerstown. Md.

18. Funeral director Andrew R. Coffman

Address Hagerstown. Md.

19. Oct 7, 1940 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1940, at 3:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept-18 1940, to Sept 22 1940 and that I last saw h. alive on Sept 22 1940.

Immediate cause of death	DURATION
Malignancy - first (diagnosis)	yrs
Sarcoma-Retro-peritoneal	9 mos
Due to Retro-peritoneal	
Due to	
Other conditions	

(include pregnancy within 3 months of death)

Major findings of operations None. Date of op.

Autopsy results None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. Coffman Blair M. D. or other

Address 214 N. Potomac St. Date signed 10/7/40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

D + Bla: r.

RECEIVED
NOV 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

Reg. Dist. No. 201 — 10936

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Washington County
City or town: Williamsport, Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Williamsport, Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 107 Vermont St
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Ned Eugene Herbert

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Baby

6 (b) Name of husband or wife: Baby
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 5 1940

8. AGE:

Years	Months	Days	If less than one day
	5	17	hrs. min.

9. Birthplace: Williamsport, Md
(Town, county, and state)

10. Usual occupation: Baby

11. Industry or business

FATHER
12. Name: William Norman Herbert
13. Birthplace: W. Va. Berkely County

MOTHER
14. Maiden name: Ethel Knode
15. Birthplace: Taylors Landing Md

18. Informant: Ethel Knode Herbert
Address: Williamsport, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 24 1940 (month) (day) (year)
Cemetery or crematory: Riverview Cemetery
Location: Williamsport, Md

18. Funeral director: Edith V Leaf
Address: Williamsport, Md

19. Oct 24 1940 (Date rec'd by registrar) Mrs E Lee McElroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 22 1940, at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 21 1940, to Oct. 22 1940, and that I last saw him alive on Oct. 22, 1940.

Immediate cause of death	DURATION
Capillary Bronchitis	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury Injured at work?

23. SIGNATURE: J. M. Cummings, M. D. or other
Address: Williamsport Md Date signed: 10/25/40

RECEIVED
NOV 4 1940
BUREAU V. M.

10937

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or ~~town~~ near: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 2102 Lexington ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or ~~town~~ near: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2102 Lexington ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Ann J. Hetzer

3. (b) Social Security Number: none

4. Sex: Female

5. Color or race: white

6.(a) Single, married, widowed, or divorced: widow

6.(b) Name of husband or wife: Charles S. Hetzer

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Aug 22. 1863

8. AGE: Years 77 | Months 1 | Days 17 | If less than one day ..... hrs. ..... min.

9. Birthplace: Mooreville, Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: own Home.

FATHER
12. Name: Isaac Moore
13. Birthplace: Mooreville, Md.

MOTHER
14. Maiden name: Matilda Mill
15. Birthplace: Parkhead Md.

16. Informant: Shelton Hetzer
Address: Hagerstown Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Oct 12-1940 (month) (day) (year)

Cemetery or ~~crematory~~: Rose Hill

Location: Hagerstown Md

18. Funeral director: C. M. Suter & Sons
Address: Hagerstown, Md.

19. Oct. 11. 1940 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 9, 1940, at 7:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 9, 1940, to Oct 9 1940 and that I last saw her alive on Oct 8, 1940

	DURATION
Immediate cause of death: Chronic myocarditis	5 yrs.
Due to: Generic arteriosclerosis	Indef.
Due to:	
Other conditions: Senile Psychosis	1 year.

(Include pregnancy within 3 months of death)

Major findings of operations: X

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: X Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: B B Kreisler MD M. D. or other

Address: Hagerstown Md. Date signed: 10/11/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

10938

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or ~~street~~ address where death occurred: Washington Co.
How long in hospital or ~~institution~~? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 822 Oak Hill
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Orpha M. Hutzell

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife: John L. Hutzell
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Aug 5 - 1863

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
77	2	11		

9. Birthplace: Rocky Ridge Fred. Co. Md (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: own Home
FATHER 12. Name: Benjamin Routzhan
FATHER 13. Birthplace: Frederick Co. Md
MOTHER 14. Maiden name: Elizabeth Bittle
MOTHER 15. Birthplace: Myersville Md.
16. Informant: Mrs. Robert Carter
Address: Hagerstown Md
17. (Burial, cremation, or removal. Which?) Burial — Date thereof (month) (day) (year) Oct 18-1940
Cemetery or ~~crematory~~: Rose Hill
Location: Hagerstown Md
18. Funeral director: C. M. Suter & Sons
Address: Hagerstown Md
19. (Date rec'd by registrar) Oct 17. 1940 — Registrar: Chas A Bowers

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 16 1940 at 5.10 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-14 1940, to 10-16 1940 and that I last saw her alive on 10-16 1940

Immediate cause of death	DURATION
Cerebral Hemorrhage	48 Hours
Due to: Hypertensive vascular disease & generalized arteriosclerosis	Unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: Not done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ____ Injured at work?

23. SIGNATURE: John N Hornbaker M.D. (M. D. or other)
Address: 158 W. Washington St - Hagerstown, Md - Date signed: 10-16-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 6 1940

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (161-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 10939

1. PLACE OF DEATH:

County Washington

City or town Mt. Briar

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wash.

City or town Mt. Briar Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF YETERAN, NAME WAR

3. (a) FULL NAME Gordon Frederick Jones Illegitimate (Gordon Frederick McCoy)

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12, 1940

8. AGE:

Years	Months	Days	If less than one day
	1	2	hrs. min.

9. Birthplace Mt Briar - Wash. - Md

(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER

12. Name Ira Franklin Jones

13. Birthplace Mt. Briar

MOTHER

14. Maiden name Margie McCoy

15. Birthplace Keedysville Md

16. Informant Ira Franklin Jones

Address Mt. Briar

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-15-1940 (month) (day) (year)

Cemetery or crematory Mt. View

Location Sharpsburg, Md

18. Funeral director R. D. E. Grushaw

Address Keedysville, Md

19. Oct 14 1940 (Date rec'd by registrar) Mrs Katherine Dagenhart Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1940, at 9 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 14 1940, to Oct. 14 1940, and that I last saw him alive on Oct. 14 1940.

Immediate cause of death	DURATION
Nose bleed idiopathic	10/13/40
Due to Hemorrhage and shock	10/14/40
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations 0

Of autopsy as above Oct14/40

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Robert Wells DEPUTY MEDICAL EXAM. WASH. CO., MD. M. D. or other

Address Hagerstown, Md. Date signed 10/14/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Sept 27 - 1940
Dec 1 - 1874

RECEIVED
NOV 6 1940

10940

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(13)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Near Chewsville, Md. R.F.D.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yr.

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wash.

City or town Near Chewsville Md Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. none
(If rural, give LOCATION)

2.(a) If veteran, name war none

3.(a) FULL NAME Martha Arbeliane Jones

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife Hubert Edward Jones

6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) 4-31-1876 July 31, 1876

8. AGE:

Years	Months	Days	If less than one day
64	2	8	hrs. min.

9. Birthplace Boonsboro Wash. Co Md
(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business none

FATHER
12. Name Abraham Philhour
13. Birthplace Hackenstown New Jersey

MOTHER
14. Maiden name Malinda Green
15. Birthplace Boonsboro Wash Co Md

16. Informant Rev W. A. Miller
Address Smithsburg Md R.F.D.

Boonsboro Cemetery
(Burial, cremation, or removal. Which?)

Date thereof 10-13-1940
(month) (day) (year)

Cemetery or crematory Boonsboro Cemetery

Location Boonsboro Wash Co Md

18. Funeral director Geo. B. Hoover
Address Smithsburg Wash Co Md

19. October 11 1940 Chas H Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1940 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 23 1940, to Oct 9 1940 and that I last saw her alive on Oct 9 1940

Immediate cause of death Arterio-sclerotic Heart Disease

Due to

Due to

Other conditions Chronic Fibroid Tuberculosis
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Sidney Novenstein
M. D. or other

Address Fulkstown, Md Date signed Oct 10 1940

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOV 6 1940

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1310)

10941

CERTIFICATE OF DEATH

Reg. Diat. No. 382

1. PLACE OF DEATH:

County: Washington

City or ~~town~~: Hagerstown

(If outside city or town limits, write RURAL and give nearest towo)

How long in above placo of death? 33 yrs.

Hospital, institution, or street address where death occurred: 953 Main ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 953 Main ave

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Eliza Virginia Keckley

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or ~~wife~~: Jacob R. Keckley

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): June 27 - 1869.

8. AGE: Years	Months	Days	If less than one day
71	3	6	... hrs. ... min.

9. Birthplace: Star Tannery Frederick Co. Va (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: own Home

FATHER — 12. Name: Bird

FATHER — 13. Birthplace: Frederick Co, Va

MOTHER — 14. Maiden name: not known

MOTHER — 15. Birthplace: Frederick Co. Va

16. Informant: Mrs. Neva Malone

Address: Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 7-1940 (month) (day) (year)

Cemetery or ~~crematory~~: Rose Hill

Location: Hagerstown, Md.

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown Md

19. Oct. 5. 1940 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/3 1940, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1940, to 10/3 1940 and that I last saw her alive on 10/3 1940

Immediate cause of death	DURATION
Hypertension and arteriosclerotic Cardio Vascular Renal disease	10 yr
Due to	
Due to	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: F F Leahy M. D. or other

Address: 170 W Wash St Date signed: 10/4/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

NOV 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-a)

10942

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs.

Hospital, institution, or street address where death occurred: Wash. Co Hospital

How long in hospital or institution? 2 das.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown (If outside city or town limits, write RURAL and give nearest town)

Street No. 644 W. Washington St (If rural, give LOCATION)

2.(a) If veteran, name war No

3. (a) FULL NAME Deskin A. Kidwell

3. (b) Social Security Number 220-09-7778

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married.

6.(b) Name of husband or wife: Virginia B

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 15 - 1866

8. AGE: Years 74 | Months 3 | Days 11 | If less than one day ..... hrs. ..... min.

9. Birthplace: Romney Hampshire Co. W.Va. (Town, county, and state)

10. Usual occupation: Night Watchman

11. Industry or business: Baker-Long Co.

FATHER

12. Name: William Kidwell

13. Birthplace: North River Mills. W.Va

MOTHER

14. Maiden name: Nancy Mentzer

15. Birthplace: North River Mills. W.Va.

16. Informant: Guy S. Kidwell

Address: Hagerstown. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 29-1940 (month) (day) (year)

Cemetery or crematory: Kidwell Cemetery

Location: Slanesville W.Va.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. October 28 1940 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 26 1940 at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-26 1940, to 10-26 1940 and that I last saw him alive on 10-26-40 19..

	DURATION
Immediate cause of death: Acute pulmonary Edema	24 hours
Due to: Surgical shock (post-operative)	24 "
Due to:	
Other conditions: Strangulated hernia, inguinal	~~7 years~~ 24 hours

(Include pregnancy within 3 months of death)

Major findings of operations: Inguinal herniorrhapy. Date of op. 10-25-40

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John H Hornbaker M. D. or other

Address: 158 W. Washington St. Date signed: 10-28-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Hawk Dr. Bunker

RECEIVED
NOV 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

10943

Reg. Dist. No. 382

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 mo
Hospital, institution, or street address where death occurred: 4 Kaplan Row
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4 Kaplan Row
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Kenneth Wade Knight

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	—

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): June 5 - 1940

8. AGE: Years	Months	Days	If less than one day
	5	25	____ hrs. ____ min.

9. Birthplace: Hagerstown
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Jessie Knight
13. Birthplace: Luray Va

MOTHER
14. Maiden name: Alice Allen
15. Birthplace: Luray Va

16. Informant: Alice J Knight
Address: 4 Kaplan Row

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Nov 1-1940
(month) (day) (year)

Cemetery or crematory:
Location: Luray Va

18. Funeral director: J.M Caldwell
Address: Hagerstown Md

19. 11-1 1940 Chas H Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30 1940 at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____
and that I last saw h im alive on ____ 19____

Immediate cause of death	DURATION
Suffocation by drowning	1940
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: Oct. 30'40
Where did injury occur? Hagerstown (City or town) Wash. (County) Md. (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Drowned Injured at work?

23. SIGNATURE: A. Robert Wells DEPUTY MEDICAL EXAM. WASH. CO., MD.
M. D. or other
Address: Hagerstown, Md. Date signed: 11/1/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 6 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (83b)

10944

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH:
County Washington
City or town Smithsburg - Maple Ave.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, ~~hospital, or institution~~: Maple Ave No Number
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 11 yr.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Wash.
City or town Maple Ave. Smithsburg Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. none
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR none

3. (a) FULL NAME Emma Alice Kuhn

3. (b) Social Security Number none

4. Sex: Female
5. Color or race: White
6. (a) ~~Single, married~~, widowed, ~~or divorced~~: widowed

B (b) Name of husband ~~or wife~~ Alvey C. Kuhn
Died 18 yr ago B(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 7-31-1862 July 31, 1862

8. AGE: Years 78 Months 2 Days 16 If less than one day — hrs. — min.

9. Birthplace Walfsville Fred Co Md
(Town, county, and state)
10. Usual occupation House Keeping
11. Industry or business —
FATHER 12. Name Samuel Farsht
13. Birthplace Walfsville Fred Co Md
MOTHER 14. Maiden name Malinda Wolf
15. Birthplace Walfsville Fred Co Md
16. Informant Mrs Vada Ashby
Address Smithsburg Md

17. (Burial, cremation, or removal. Which?) Date thereof 10-19-1940 (month) (day) (year)
Cemetery or ~~crematory~~ Smithsburg Cemetery
Location Smithsburg Wash. Co
18. Funeral director Geo B Hoover
Address Smithsburg Md

19. Oct 18 1940 (Date rec'd by registrar) Geo. W. Ferguson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1940, at 6.40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 17 1940, to Oct 17 1940, and that I last saw her alive on Oct 17 1940

Immediate cause of death	DURATION
Cerebral Thrombosis	1 hour
Due to Arteriosclerosis	10 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE G. G. Kohler M. D. or other
Address Smithsburg Date signed 10/17/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

NOV 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10945

Reg. Dist. No. 306

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH

County: Washington

City or town: Near Smithsburg Md. R.F.D.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Still Born R.F.D.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington.

City or town: Near Smithsburg Wallace Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.: none
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME

Still Born. Law

3.(b) Social Security Number

none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: none

6.(c) If alive, give age ... years

7. Birth date (mo., day, yr.) deceased: 10-30-1940

8. AGE: Years	Months	Days	If less than one day
no	no	no	no hrs. no min.

9. Birthplace: Near Smithsburg Wash Co md
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER
12. Name: Elmer E. Law.
13. Birthplace: Canty. Md

MOTHER
14. Maiden name: Elizabeth Pauline Long
15. Birthplace: Smithsburg Wash. Co md

18. Informant: Elmer E. Law.
Address: Smithsburg Wash Co md

17. Burial (Burial, cremation, or removal, which?) Date thereof: 10-31-1940 (month) (day) (year)
Cemetery or crematory: Smithsburg Cemetery.
Location: Smithsburg Wash. Co Md

18. Funeral director: Geo. B. Hoover
Address: Smithsburg md

19. Oct 30 1940 (Date rec'd by registrar) Geo. W. Ferguson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30, 1940 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 30, 1940, to Oct 30, 1940
and that I last saw him alive on ... 19...

Immediate cause of death	DURATION
Still born	
Prolonged labor	
Due to: Pre eclamptic toxemia	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Walter L. Wolfinger M. D. or other

Address: Smithsburg, Maryland Date signed: 10-30-40

RECEIVED
NOV 6 1940
BUREAU V. S.

10946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(8)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Washington County Hospital

Stay in hospital or inst. (yrs., or mos., or days) Still born

Stay in this community (yrs., or mos., or days) "

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa. County

City or town Still born Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Still born fetus Leidig

3. (b) Social Security Number

4. Sex: male

5. Color or race: white

6. (a) Single, married, widowed, or divorced: Still born

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day hrs. min.

Still born

9. Birthplace (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name Raymond Harry Leidig

13. Birthplace Dayton Ohio

MOTHER

14. Maiden name Mabel Lorraine Miller

15. Birthplace Gilford, Penna.

16. Informant Mrs. Leidig

Address Greencastle, Pa.

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Oct. 10. 1940 Chas H Bowers

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1940, at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,

and that I last saw h alive on 19 .

Immediate cause of death

Due to Still born

Due to Spontaneous abortion

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur Baptista, Jr. M.D. M. D. or other

Address 214 N. Potomac St. Date signed 10-7-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BUREAU V. S.

Hospital Disposal by
cremation
See Birth Certificate
for additional information

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10947

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

V3 A15

1. PLACE OF DEATH

County Washington

City or town Hagerstown R D #4

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 35 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown R 2 Ward No. 4

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME DAVID R LESHER

3. (b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widow

6 (b) Name of husband or wife Elizabeth Lesher

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Oct 20. 1860

8. AGE:

Years	Months	Days	If less than one day
79	11	25	____ hrs. ____ min.

9. Birthplace Penna (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business Minister

FATHER

12. Name Abram Lesher

13. Birthplace Pa

MOTHER

14. Maiden name Susan Reiff

15. Birthplace Md.

16. Informant Mrs Emma Martin

Address Hagerstown md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 18. 1940 (month) (day) (year)

Cemetery or crematory Reiff

Location near Cearfoss md

18. Funeral director A E Minnich

Address Greencastle, Pa

19. October 17 1940 (Date rec'd by registrar) Janet M. Foltz Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1940, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1940, to Oct 15 1940, and that I last saw him alive on Oct 15 - 41 19____.

Immediate cause of death	DURATION
Chr. Myocarditis	5 yrs
Due to arterio sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Dt operations

Dt autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J W Foltz M. D. or other

Address Hagerstown Md Date signed 10/16/40

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BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10948

Reg. Dist. No. 304

1. PLACE OF DEATH:
County WASHINGTON
City or town HANCOCK MD.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or insf. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County WASHINGTON
City or town HANCOCK Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. BLUE HILL ADDITION
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR No

3. (a) FULL NAME RAYMOND. A. LITTON.

3. (b) Social Security Number NONE.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ETHEL. R LITTON
6(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) July 31 1879

8. AGE: Years 61 | Months 2 | Days 0 | If less than one day: hrs. min.

9. Birthplace HALTON CO PA.
(town, county, and state)

10. Usual occupation RETIRED.

11. Industry or business

FATHER
12. Name THOMAS B LITTON
13. Birthplace FULTON CO PA

MOTHER
14. Maiden name SARAH. C. DAVIS.
15. Birthplace FRED CO. MD.

16. Informant ETHEL R LITTON
Address HANCOCK MD.

17. BURIAL Date thereof 10-4-40
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory DAMASCUS CEM. PA
Location FULTON CO PA.

19. Funeral director T. P. JENKINS
Address HANCOCK MD.

19. 10/1 19 40 J R Jenkins
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-1 19 40, at 2.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-1 19 40, to 10-1 19 40, and that I last saw h- alive on 10-1 19 40.

Immediate cause of death	DURATION
Coronary Thrombosis	10-1-40
Cerebral Embolism	10-1-40
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Herbert R. Johns M. D.
M. D. or other
Address Hancock Md Date signed 10-1-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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NOV 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (836)

CERTIFICATE OF DEATH

10949

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days.
Hospital, institution, or street address where death occurred:
Wash. Co Home
How long in hospital or institution? 3 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maylaw County Washington.
City or town near Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. Hughs Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war no

3.(a) FULL NAME Miss Jennie Lowry.

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6.(b) Name of husband or wife none
6.(c) If alive, give age —. years

7. Birth date of deceased (mo., day, yr.) Sept 8 - 1867

8. AGE: Years	Months	Days	If less than one day
73	1	4.	...hrs. ...min.

9. Birthplace Maplerville Wash Co Md. (Town, county, and state)
10. Usual occupation House work
11. Industry or business —.

FATHER
12. Name James Lowry
13. Birthplace Waynesboro Pa.

MOTHER
14. Maiden name Mary C. Hoover.
15. Birthplace Reedysville Md.

16. Informant Mary M. Hoffman
Address Hagerstown Md Rt#2

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 14-1940 (month) (day) (year)
Cemetery or crematory Fahrney's Cemetery.
Location Maplerville Md.

18. Funeral director Andrew K. Cost man
Address Hagerstown Md.

19. October 14 1940 (Date rec'd by registrar) Chas H Hoover Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12 1940, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 7 1940 to Oct 12 1940
and that I last saw her alive on Oct. 12 1940

Immediate cause of death	DURATION
Cerebral Thrombosis	5 hrs
Due to	
Due to	
Other conditions Arterio Sclerosis	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE J. N. Bradley M.D.
Address Hagerstown Md. M. D. or other
Date signed 10/14/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Bradley.

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10950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(159)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 218 E. Antietam Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Terry Lee Mann

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 7, 1940

8. AGE: Years: 0 | Months: 0 | Days: 3 | If less than one day: hrs. min.

9. Birthplace: Hagerstown- Wash. Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Floyd W. Mann
13. Birthplace: Clearspring, Md.

MOTHER
14. Maiden name: Clara B. McCune
15. Birthplace: Hagerstown, Md.

16. Informant: Floyd W. Mann
Address: Hagerstown, Md. 218 E. Antietam

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 10, 1940 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss
Address: Hagerstown, Md.

19. Oct. 10. 1940 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 9, 1940 at 11:40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 7 1940 to Oct. 9 1940 and that I last saw h in alive on Oct. 8 1940.

Immediate cause of death	DURATION
Pre-Mature	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: E. T. Poole M.D. M. D. or other
Address: Hagerstown Md Date signed: Oct. 10 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 6 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1860)

10951

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, Institution, or street address where death occurred: Washington Co. Hospital

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Wash.

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 600 N. Mulberry St
(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Sophia C. Matthaei

3. (b) Social Security Number None

4. Sex Female

5. Color or race white

6.(a) Single, married, widowed, or divorced widow

6.(b) Name of husband or wife Chas.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feby 10 - 1862

8. AGE: Years 78 Months 8 Days 20 If less than one day ..... hrs. ..... min.

9. Birthplace Martinsburg Berkeley Co. W-Va
(Town, county, and state)

10. Usual occupation None

11. Industry or business —

FATHER
12. Name No Record
13. Birthplace " "

MOTHER
14. Maiden name No Record
15. Birthplace " "

16. Informant Wilson A Caskey

Address 600 N Mulberry Hagerstown

17. Oct 30 - 1940 (~~Burial, cremation,~~ or removal. ~~Which?~~) Date thereof Oct 30 - 1940 (month) (day) (year)

Cemetery or crematory Martinsburg W. Va

Location Martinsburg "

18. Funeral director Andrew K. Coffman

Address Hagerstown. Md.

19. October 30 1940 (Date rec'd by registrar) Margaret B. Bowers Registrar Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1940 at 4:25 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 14 1940 to Oct 30 1940 and that I last saw him alive on Oct 30 1940

Immediate cause of death	DURATION
Broncho pneumonia	10/20/40
Due to Fracture Left Hip; due to an accidental fall. C.W.G.R.	10/14/40
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, ~~suicide, or homicide~~ Accident Date of Oct. 13, 1940.

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) in her home

Means of injury Accidental fall Injured at work?

23. SIGNATURE H. L. Porterfield M.D. M. D. or other

Address 136 W Washington St Date signed 10/30/40

RECEIVED
NOV 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10952

55-E

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or ~~town~~: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yr.

Hospital, Institution, or street address where death occurred: 866 Virginia ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or ~~town~~: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 866 Virginia ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John Franklin Matthews

3. (b) Social Security Number: 705-10-4795

4. Sex: Male

5. Color or race: white

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of ~~husband~~ or wife: Carrie R. Matthews

6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): Dec 1 - 1883

8. AGE: Years: 56 Months: 10 Days: 4 If less than one day: hrs. min.

8. Birthplace: Carlisle, Cumberland Co. Pa.

(Town, county, and state)

10. Usual occupation: Telegraph Operator

11. Industry or business: W.M.R.R. Co.

FATHER

12. Name: John C. Matthews

13. Birthplace: Carlisle, Pa.

MOTHER

14. Maiden name: Emma P. Pentz

15. Birthplace: Dillsburg, Pa.

16. Informant: Mrs. J. F. Matthews

Address: Hagerstown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 7 - 1940 (month) (day) (year)

Cemetery or ~~crematory~~: Rest Haven

Location: Hagerstown, Md.

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Md.

19. Oct. 7. 1940 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 5 1940, at 12 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 - 1940, to 10/5 1940 and that I last saw him alive on 19

Immediate cause of death	DURATION
Sarcoma of right shoulder	2 years
Due to —	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op. —

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ✓ Date of: ✓

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ✓ Injured at work? ✓

23. SIGNATURE: Victor D. Miller M. D. ~~or other~~

DR. VICTOR D. MILLER, 131 W. WASHINGTON, ST. HAGERSTOWN, MD.

Address: Date signed: 10/5 1940

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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NOV 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93-1

10953

CERTIFICATE OF DEATH

Reg. Dist. No. 307

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 yrs
Hospital, Institution, or street address where death occurred:
20 East Lee
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 20 East Lee
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Emma S. Metz

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widow

6.(b) Name of husband or wife: Jesse A. Metz
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): July 4 - 1863

8. AGE: Years	Months	Days	If less than one day
77	2	29	hrs. min.

9. Birthplace: Williamsport, Wash. Co. Md. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: own Home
FATHER 12. Name: Joseph Farrow
FATHER 13. Birthplace: Williamsport, Md
MOTHER 14. Maiden name: Susan Fitzell
MOTHER 15. Birthplace: Williamsport, Md.
16. Informant: William L. Metz
Address: Hagerstown, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 5 1940 (month) (day) (year)
Cemetery or crematory: Rest Haven
Location: Hagerstown, Md.
18. Funeral director: L. M. Suter & Sons
Address: Hagerstown, Md.
19. Oct 5, 1940 (Date rec'd by registrar) Chas H Rogers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 3 1940 at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 3 1940 to Oct 3 1940 and that I last saw her alive on Oct 3 1940

Immediate cause of death	DURATION
Acute heart failure	
Due to: Hypertension	
Due to:	
Other conditions: Myocardial degeneration	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: H. Allen Seymour M.D. M. D. or other
Address: Hagerstown, Md. Date signed 10-4-40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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NOV 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10954

Reg. Dist. No. 31

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Washington County

City or town Williamsport, Md RFD #1
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Williamsport Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. RFD #1
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Doris Marie Myers

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Baby

B (b) Name of husband or wife Baby

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Aug 28 1940

8. AGE:

Years	Months	Days	If less than one day
	2	2	____ hrs. ____ min.

9. Birthplace Williamsport, Md RFD #1
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Earl Myers

13. Birthplace Williamsport, Md

MOTHER 14. Maiden name Blanche Bowers

15. Birthplace Williamsport, Md

16. Informant Earl Myers

Address Williamsport, Md RFD #1

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 1 1940 (month) (day) (year)

Cemetery or crematory Greenlawn Cemetery

Location Williamsport, Md

18. Funeral director Edith V Leaf

Address Williamsport, Md

19. Oct. 31. 1940 (Date rec'd by registrar) J. S. Bloom Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1940, at 9:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 27 1940, to Oct. 30 1940, and that I last saw h-er alive on Oct. 30 1940,

	DURATION
Immediate cause of death Lobar Pneumonia	3 Days
Due to Common Cold	10 Days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Dt operations

Dt autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C F Young M.D. or other

Address Williamsport Md Date signed 10/31/40

RECEIVED
NOV 5 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

10955

1. PLACE OF DEATH

County Washington Registration Dist. No. 302

Village or City Hagerstown No. Washington County Hospital St., 3 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residance in city or town whare death occurred Stillborn mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Stillborn Baby Girl Needy

(a) Residence: No. Stillborn St., Ward. Boonsboro

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female

4. COLOR OR RACE white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Stillborn

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Stillborn

6. DATE OF BIRTH (month, day, end yaar) October 24, '40

7. AGE Yaars Months Days If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profassion, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Stillborn

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month end year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Hagerstown, Md. (State or country)

FATHER

13. NAME Randolph Ellsworth Needy

14. BIRTHPLACE (city or town) Boonsboro, Md. (State or country)

MOTHER

15. MAIDEN NAME Elizabeth Huffer Gilbert

16. BIRTHPLACE (city or town) Boonsboro, Md. (State or country)

17. INFORMANT Mrs. Needy (mother) (Address) Boonsboro, Md.

18. BURIAL, CREMATION, OR REMOVAL

Place Date , 19

19. UNDERTAKER (Address)

20. FILED Oct. 29, 1940 Chas H. Bowers Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH October (Month) 24 (Day) , 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Stillborn , 19

I last saw h alive on , 19 ; death is said to have occurrad on the date stated above, at 4:30 P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of Importance were as follows:

Date of onset

Intrauterine asphyxia

Othar Contributory Causes of importance:

Name of oparation Date of

What tast confirmed diagnosis? Was thare an autopsy?

23. If daath was due to axternal causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicida? Dete of Injury , 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, In HOME, or in PUBLIC PLACE.

Manner of injury

Neture of Injury

24. Was disease or injury In any way ralated to occupation of daceasad?

If so, specify

(Signad) G. Baptiste, Jr. M. D.

(Address) 214 N. Potomac St. Hagerstown, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

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BUREAU V. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (151)

CERTIFICATE OF DEATH

10956

Reg. Dist. No. 307

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs 6 mo.

Hospital, institution, or street address where death occurred:

Washington County Home

How long in hospital or institution? 3 yrs 6 mo

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wash.

City or town Boonsboro

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Addie E. Nyman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) July 5 1866

8. AGE: Years 74 | Months 7 | Days 17 | If less than one day ... hrs. ... min.

9. Birthplace Boonsboro Wash. Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Geo W Nyman

13. Birthplace Boonsboro Md.

MOTHER 14. Maiden name Mary Smith

15. Birthplace Sharpsburg Md

16. Informant Mrs Ezra Chapman

Address Hag Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 23 1940 (month) (day) (year)

Cemetery or crematory Boonsboro Cemetery

Location Boonsboro Md

18. Funeral director Scott J Minnich & Son

Address Hagerstown Md

19. Oct 22 1940 (Date rec'd by registrar) Chas H Travers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1940 at 7A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 10 1940 to Oct. 21 1940 and that I last saw h[illegible] alive on Oct. 21 1940

Immediate cause of death	DURATION
(a) Septicaemia	3 Days.
Due to	
Due to (b) Carbuncle.	1 Wk.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Beachley M.D. M. D. or other

Address Hagerstown, Md. Date signed 10/22/40

RECEIVED
NOV 6 1940
BUREAU V. S.

10957

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 54 years

Hospital, institution, or street address where death occurred: 213 Jefferson Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 213 Jefferson Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Bertha Mabel Osborne

3.(b) Social Security Number 214-09-4624

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) January 25, 1886

8. AGE: Years 54 | Months 8 | Days 20 | If less than one day ... hrs. ... min.

9. Birthplace: Washington County, Md.
(Town, county, and state)

10. Usual occupation: Factory Worker

11. Industry or business: Knitting Mills

FATHER
12. Name: James Osborne
13. Birthplace: Waynesboro, Pa.

MOTHER
14. Maiden name: Eliza Ridenour
15. Birthplace: Hagerstown, Md.

16. Informant: Mrs. Eliza J. Ernde
Address: Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 18, 1940 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss
Address: Hagerstown, Md.

19. Oct. 18 1940 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 15, 1940 11:20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 15 1940 to Oct. 15 1940 and that I last saw her alive on Oct 15 1940

Immediate cause of death	DURATION
Acute pulmonary oedema	1 hour
Acute cardiac dilatation	2
Due to: Chronic myocarditis	1
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: B F Prather M. D. ~~or other~~

Address: Hagerstown Md Date signed: Oct. 16 40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 6 1940
BUREAU V. S.

10958

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(48-B)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs. 7 mos.

Hospital, institution, or street address where death occurred: 1823 Virginia Ave.

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1823 Virginia Ave
(If rural, give LOCATION)

2.(a) If veteran, name war no

3. (a) FULL NAME Mrs Mattie M. Pittinger.

3. (b) Social Security Number none.

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widow.

6.(b) Name of husband or wife Thomas.

6.(c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) June 1- 1873.

8. AGE: Years 67 Months 4 Days 7. If less than one day ..... hrs. ..... min.

9. Birthplace Indian Springs, Wash Co Md.
(Town, county, and state)

10. Usual occupation Housewife.

11. Industry or business ——.

FATHER
12. Name Thomas Corbett.
13. Birthplace Indian Springs Md.

MOTHER
14. Maiden name Louisa McAllister.
15. Birthplace Indian Springs Md.

16. Informant Mrs Howard E Toms
Address Hagerstown Md.

17. Burial. Date thereof Oct 10-1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cem.

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman
Address Hagerstown, Md.

19. Oct. 9. 1940 Chas H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 1940, at 9.30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1- 1940, to Oct 8- 1940 and that I last saw her alive on Oct 8-40 19

Immediate cause of death Carcinoma uterus

Due to

Due to

Other conditions

DURATION: 6 months

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. E. W. Ditto M. D. or other

Address Hagerstown Md Date signed 10/8/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Ditto

RECEIVED
NOV 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (43)

CERTIFICATE OF DEATH

10959

Reg. Dist. No. 316

1. PLACE OF DEATH:

County: Washington

City or town: near Keedysville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life.

Hospital, institution, or street address where death occurred: near Keedysville (Rural)

How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Rural - near Keedysville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: near Keedysville Md.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Raleigh Poffenberger

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Sarah E. Poffenberger

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 26 - 1864

8. AGE: Years	Months	Days	If less than one day
76	0	15	..... hrs. ..... min.

9. Birthplace: Near Keedysville Wash. Co. Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Own Farm

FATHER 12. Name: Elias Poffenberger

FATHER 13. Birthplace: Near Keedysville Wash. Co. Md.

MOTHER 14. Maiden name: Mary Elizabeth Showman

MOTHER 15. Birthplace: near Keedysville Wash. Co. Md.

16. Informant: Mrs. Howard Remsburg

Address: Sharpsburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 15. 1940 (month) (day) (year)

Cemetery or crematory: Bakersville Cemetary

Location: Bakersville Md.

18. Funeral director: Wm F. Bast & Son

Address: Boonsboro Md

19. Oct. 14. 1940 (Date rec'd by registrar) W. H. Keefer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11, 1940 at 11 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive on ..... 19.....

Immediate cause of death	DURATION
Fractured skull with	
Due to intra cranial hemorrhage and laceration of brain	10/11/40
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. .....

Autopsy results: as above 10/12/40

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Homicide Date of: Oct. 11'40

Where did injury occur? Near Keedysville (City or town) Wash. (County) Md. (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Beaten Injured at work? no

23. SIGNATURE: R. Robert Mullendore M.D. DEPUTY MEDICAL EXAM. WASH. CO., MD. M. D. or other

Address: Hagerstown, Md. Date signed: 10/14/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

10960

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yr
Hospital, Institution, or street address where death occurred: 711 Oak Hill ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 711 Oak Hill ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Daniel E. Poole

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Anna D. Poole
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 4-1870

8. AGE: Years	Months	Days	If less than one day
70	0	28	..... hrs. ..... min.

9. Birthplace: Beaver creek Washington Co, Md. (Town, county, and state)
10. Usual occupation: Retired Salesman
11. Industry or business: Standard Oil Co.
FATHER 12. Name: Daniel N. Poole
13. Birthplace: Westminster, Md.
MOTHER 14. Maiden name: Mary A. Ridenour
15. Birthplace: Beaverbreek Md.
16. Informant: Mrs Anna D. Poole
Address: Hagerstown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 4-1940 (month) (day) (year)
Cemetery or crematory: Rose Hill
Location: Hagerstown, Md.
18. Funeral director: C. M. Suter & Sons
Address: Hagerstown, Md.
19. Oct. 4, 1940 (Date rec'd by registrar) Chas. H. Howard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 1, 1940, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 30 1940, to Oct. 1 1940
and that I last saw h[illegible] alive on Oct. 1, 1940

Immediate cause of death	DURATION
a. Uremia	2 days
Due to: Chronic Nephritis	2 yrs.
Due to: Arteriosclerosis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or Coroner
Address: Hagerstown Date signed: Oct. 4. 40

RECEIVED
OCT 10 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (55-B)

Reg. Dist. No. 304.

10961

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County WASHINGTON

(b) City or town HANCOCK MD. (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State MD (b) County WASH.

(c) City or town HANCOCK. (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) If foreign born, how long in U. S. A.? LIFE years

3 (a) FULL NAME VERA WILDA PRYOR.

3 (b) If veteran, name war NONE.

3 (c) Social Security No. NONE.

4. Sex FEMALE 5. Color or race WHITE 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife CLARENCE EARL PRYOR 6. (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) MAY 28 1904

8. AGE: Years 36 Months 4 Days 6 If less than one day ____ hr. ____ min.

9. Birthplace EVERETT PA. (Town, county, and state)

10. Usual occupation HOUSEWIFE.

11. Industry or business OWN HOME.

FATHER 12. Name EMERSON CLARK.

13. Birthplace PENNA.

MOTHER 14. Maiden Name BELLEWIGFIELD.

15. Birthplace PENNA.

16 (a) Informant CLARENCE E PRYOR.

(b) Address HANCOCK MD.

17 (a) BURIAL. (Burial, cremation, or removal) (b) Date thereof OCT 7 1940 (month) (day) (year)

(c) Cemetery or crematory RIVERVIEW.

Location HANCOCK MD.

18 (a) Funeral director T P JENKINS.

(b) Address HANCOCK MD.

19 (a) 10/4/40 (Date rec'd by registrar) (b) T P Jenkins Registrar

MEDICAL CERTIFICATION

20. Date of death OCT. 4 1940, at 315 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/15/35, to 10/4/40, and that I last saw him alive on 10/2/40.

Immediate cause of death metastasis of Sarcoma — Duration 6 mo

Due to Sarcoma of R Hip — 3 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations Sarcoma Giant Cell

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H E Tabler MD M. D. or other

Address Hancock Md. Date signed 10-4-40

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1940
U. S.

10962

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 wks.

Hospital, institution, or street address where death occurred: Wash. Co Home -

How long in hospital or institution? 4 wks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown -
(If outside city or town limits, write RURAL and give nearest town)

Street No. Middleburg Pike
(If rural, give LOCATION)

2.(a) If veteran, name war no

3. (a) FULL NAME William Duce Pryor.

3. (b) Social Security Number 218-09-3641

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: widower.

6.(b) Name of husband or wife: Elizabeth

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Feby 4 - 1886.

8. AGE: Years 54 | Months 8 | Days 5 | If less than one day ..... hrs. ..... min.

9. Birthplace: Lantz Fred. Co Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: —.

FATHER
12. Name: William Pryor.
13. Birthplace: Lantz Md.

MOTHER
14. Maiden name: Sarah A Brown.
15. Birthplace: Lantz Md.

16. Informant: Clarence Pryor.
Address: Highfield Md.

17. Burial. Date thereof: Oct 12-1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Mt Bethel Cemetery

Location: Cascade Md.

18. Funeral director: M.L. Creager and Son.
Address: Thurmont Md.

19. Oct. 9. 1940 Chas H Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 9. 1940, at 6 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1 1940, to Oct 9 1940 and that I last saw h. im alive on Oct. 9 1940

Immediate cause of death: Cerebral Thrombosis

Due to:

Due to:

Other conditions: None

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

DURATION

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J H Beachley M. D. or other

Address: Hagerstown Md. Date signed 10/9/40

D. Beachley -

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

10963

Reg. Dist. No. 307

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Washington

City or town (Rural, Near) Harpers Ferry, W. Va. R.F.D. #1
(If outside city or town limits, write RURAL or NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or Inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 30 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town (Rural) Harpers Ferry W. Va. R.F.D. #1 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Pleasantville
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Charles Amos Reynolds

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Lottie Mae Reynolds

6(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) May 4, 1876

8. AGE: Years	Months	Days	If less than one day
64	5	13	hrs. ___ min.

9. Birthplace Ringold, Washington, Maryland
(Town, county, and state)

10. Usual occupation Salesman

11. Industry or business Product Salesman

FATHER 12. Name Silas Reynolds

13. Birthplace Maryland

MOTHER 14. Maiden name Mary Elizabeth Delozier

15. Birthplace Maryland

16. Informant Mrs. Lottie Mae Reynolds

Address Harpers Ferry, West Va. R.F.D. #1

17. Burial Date thereof Oct. 19, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Ringold Cemetery

Location Ringold, Md.

18. Funeral director J. H. Eackles

Address Bolivar, West Va.

19. Oct 17 1940 Cornelius N. Castle Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17, 1940, at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 11 1940, to Oct 16 1940, and that I last saw him alive on Oct 16 1940.

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 da.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. C. Johnson M. D. or other

Address Harpers Ferry W. Va. Date signed 10/17/40

NOV 6 1940
BUREAU U. S.

10964

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 72 - 11 - 10

Hospital, institution, or street address where death occurred: 225 Summit ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 225 Summit ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mollie A Rice

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife W Norman Rice

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 3 1867

8. AGE:

Years	Months	Days	If less than one day
72	11	20	..... hrs. ..... min.

9. Birthplace Mt Carmel Wash. Md.
(Town, county, and state)

10. Usual occupation House Duties

11. Industry or business Own Home

FATHER
12. Name Otho J. Shiffer
13. Birthplace Mt Carmel Md.

MOTHER
14. Maiden name Ann Neikark
15. Birthplace Boonesboro. Md.

16. Informant Mr. O. E. Shifley
Address Frederick Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Oct 25, 1940
(month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown Md.

18. Funeral director Scott F Minnich & Son
Address Hagerstown Md.

19. Oct. 25, 1940 Chas H Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1940, at 10.35 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/19 1940, to 10/23 1940 and that I last saw her alive on 10/23 1940

Immediate cause of death Cerebral Hemorrhage — DURATION 10/19/40

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Ans

Date of op.

Autopsy results Ans

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F F Lusby M. D. or other

Address 170 W Wash St Date signed 10/24/40

Lusby

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1940
BUREAU V. S.

Dr. Kohler

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

10966

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years.

Hospital, institution, or street address where death occurred: at Home.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown Md. (If outside city or town limits, write RURAL and give nearest town)

Street No. 61 East Ave. (If rural, give LOCATION)

2.(a) If veteran, name war none

3. (a) FULL NAME Cora Harshman Seighman

3. (b) Social Security Number None.

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife J. H. G. Seighman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November-16-1879

8. AGE: Years 60 Months 11 Days 7 If less than one day ..... hrs. ..... min.

9. Birthplace Myersville Fred. Co. Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business own Home.

FATHER
12. Name Israel Harshman
13. Birthplace Myersville Fred. Co. Md.

MOTHER
14. Maiden name Mary C. Huffer
15. Birthplace Myersville Fred. Co. Md.

16. Informant L. H. Wolfinger

Address 61 East Ave. Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 25. 1940 (month) (day) (year)

Cemetery or crematory Smithsburg Cemetary

Location Smithsburg Md.

18. Funeral director Wm. F. Bast & Son

Address Boonsboro Md

19. Oct. 23, 1940 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1940 at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10 1940 to Oct 23 1940 and that I last saw her alive on Oct 23 1940

Immediate cause of death

	DURATION
Cerebral Thrombosis	2 days
Chronic Myocarditis	10 yr
Due to Arterio Sclerosis	
Due to	
Other condition Chronic Cholecystitis	3 yr

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE G. G. Kohler M. D. or other

Address Smithsburg Date signed 10/23/40

RECEIVED
NOV 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-L)

CERTIFICATE OF DEATH

10967

Reg. Dist. No. 307

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 Years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Marylnad County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 611 Church St.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Emma C. Shirey.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6.(b) Name of husband or wife: William Shirey

Died Jan 13, 1929 6.(c) If alive, give age 73/10/18 years

7. Birth date of deceased (mo., day, yr.): Feb 1- 1860.

8. AGE: Years	Months	Days	If less than one day
80	8	3	....hrs. ....min.

9. Birthplace: GREENCASTLE, Pa. (Town, county, and state)

10. Usual occupation: Retired home work.

11. Industry or business:

FATHER — 12. Name: Hanry Hefferman

13. Birthplace: Pa.

MOTHER — 14. Maiden name: Abigall Rosenberger

15. Birthplace: Pennsylvania.

16. Informant: (Son) Warren Shirey

Address: Hagerstown

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 6, 1940 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery.

Location: Hagerstown

18. Funeral director: Fred W. Kraiss.

Address: Hagerstown

19. Oct. 6. 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 4 1940 at 12 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1- 1940 to Oct 4 1940

and that I last saw him alive on Oct 4- 1940

Immediate cause of death	DURATION
Chr. Myocarditis	10 yrs.
Due to: Arteriosclerosis	
Due to:	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operation: ....Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. D. or other

Address: Hagerstown Date signed 10-7-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
NOV 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (931)

CERTIFICATE OF DEATH

10968

Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington

City or town Sandy Mar. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Fahrney Memorial Home.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) alley.

State Maryland County Washington

City or town Hagerstown Sandy Mar. (If outside city or town limits, write RURAL and give nearest town) (WASHINGTON)

Street No. Fahrney Memorial Home (If rural, give LOCATION)

2.(a) If veteran, name war none

3. (a) FULL NAME Jannie Showacre.

3. (b) Social Security Number none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Charles. Showacre.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March. 12. 1856

8. AGE: Years	Months	Days	If less than one day
74	7	12	..... hrs. ..... min.

9. Birthplace Town Creek Md. (Town, county, and state)

10. Usual occupation Housewife.

11. Industry or business Duty Home.

FATHER 12. Name Lewis Shryock

FATHER 13. Birthplace Town Creek Md.

MOTHER 14. Maiden name Feba French

MOTHER 15. Birthplace Town Creek Md.

16. Informant Mrs. Mary B. Lugar

Address 148 S. Mulberry St. Hagerstown Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof 0-ct. 28. 1940 (month) (day) (year)

Cemetery or crematory Rest Haven Cemtay.

Location Hagerstown Md.

18. Funeral director F. W. Kraines

Address Hagerstown Md.

19 Oct. 26. 1940 (Date rec'd by registrar) William D. Bast Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1940 at 8:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 23 1940 to October 24 1940 and that I last saw her alive on October 24 1940

Immediate cause of death	DURATION
Chronic Myocarditis.	7 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE G. W. LeFan M.D (M. D. or other)

Address Boonsboro, Md Date signed 10/25/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-E)

CERTIFICATE OF DEATH

10969

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 years.
Hospital, institution, or street address where death occurred:
240 N. Potomac
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Md. County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 240 N. Potomac
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Lois E. Simon

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Jacob S. Simon
6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): March 6 1866

8. AGE: Years	Months	Days	If less than one day
74	7	11	...hrs. ...min.

9. Birthplace: Springfield Ohio (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business: Own home

FATHER
12. Name: Elisha J. Vose
13. Birthplace: Mass.

MOTHER
14. Maiden name: Julietta Cose
15. Birthplace: Ohio

16. Informant: Rev. Walter Simon
Address: Finksburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 21 1940 (month) (day) (year)
Cemetery or crematory: Rest Haven
Location: Hagerstown Md.

18. Funeral director: Scott F. Minnick & Son
Address: Hagerstown Md.

19. Oct. 18, 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 17 1940 at 10.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-11 1940, to 10-17 1940 and that I last saw her alive on 10-17 1940

Immediate cause of death	DURATION
Acute pulmonary edema	1 hour
Due to: Rheumatic Heart Disease	Unknown at least 30 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John N. Hornbaker M. D.
Address: 158 W. Washington St. Date signed: 10-18-40

Hornbaker

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(48-B)

10970

CERTIFICATE OF DEATH

Reg. Dist. No. 300

1. PLACE OF DEATH:

County Wahsington

City or town Sharpsburg Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 87

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Sharpsburg Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Laura Jane Simmons

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26 1853

8. AGE: Years	Months	Days	If less than one day
87	4	29	hrs. min.

9. Birthplace Sharpsburg Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name David B Simmons
13. Birthplace Sharpsburg Md

MOTHER
14. Maiden name Margret Ann Standback
15. Birthplace Sharpsburg Md

16. Informant Mrs. Lizzie King (sister
Address Sharpsburg Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Oct 28 1940
(month) (day) (year)

Cemetery or crematory Tolson Cemetery

Location Sharpsburg Md

18. Funeral director Edith V Leaf

Address Williamsport, Md

19. 10/28 1940 (Date rec'd by registrar) Ed Boyer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1940, at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sep 1 1939, to Oct 25 1940, and that I last saw her alive on Oct 25 1940.

Immediate cause of death Carcinoma of uterus — DURATION 2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter H. Sheely MD
M. D. or other

Address Sharpsburg Md Date signed 10-28-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10971

Reg. Dist. No. 303

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Washington County

City or town Clearspring Md RFD #1

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 5-yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Clearspring Md Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. R. F. D. #1

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Miss Martha Slayman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4 1865

8. AGE: Years	Months	Days	If less than one day
75	6	27	hrs. min.

9. Birthplace Hancock Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER — 12. Name James Sayman Scotland

13. Birthplace Hancock Md

MOTHER — 14. Maiden name Catherine Barnhart

15. Birthplace Hancodk Md

16. Informant Mrs. David Robinson(neice

Address Clearspring Md RFD #1

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 3 1940 (month) (day) (year)

Cemetery or crematory Rosehill Cemetery

Location Clearspring Md

18. Funeral director Edith V Leaf

Address Williamsport, Md

19. Nov 1 (Date rec'd by registrar) 1940 Joseph W. Murray Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31. 1940, at 7.30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1936, to Oct 31. 1940, and that I last saw him alive on Oct 30. 1940.

	DURATION
Immediate cause of death Arthritis Deformans	7 yrs.
Due to	
Due to	
Other conditions Chr. Endocarditis	2 yrs.

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE David R. Brewer M.D.

M. D. or ~~other~~

Address Clear Spring Md Date signed 11/1/40

NOV 6 1940

10972

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 135 West Washington

Stay in hospital or inst. (yrs., or mos., or days) None

Stay in this community (yrs., or mos., or days) 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa County Franklin

City or town Mercersburg Ward No. —

(If outside city or town limits, write RURAL NEAR and give town)

Street No. ✓

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR No —

3. (a) FULL NAME Spangler Henry H

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	white	Married

B (b) Name of husband or wife Louise M. Spangler Mercersburg Pa 6(c) If alive, give age 60 years

T. Birth date of deceased (mo., day, yr.) Jan 22 - 1873

8. AGE:

Years	Months	Days	If less than one day
67	9	1	— hrs. — min.

9. Birthplace Mersburg Pa. (Town, county, and state)

10. Usual occupation attorney at Law

11. Industry or business none

FATHER

12. Name Henry Spangler

13. Birthplace Mercersburg Pa

MOTHER

14. Maiden name Hannah M. Hoke

15. Birthplace Mercersburg Pa

1B. Informant Mrs Louise M. Spangler

Address Mercersburg Pa.

1T. Burial - (Burial, cremation, or removal. Which?) Date thereof 10 (month) 26 (day) 1940 (year)

Cemetery or crematory Fair view.

Location Mercersburg Pa.

1B. Funeral director J. M. Lininger

Address Mercersburg, Pa.

19 Oct. 24, 1940 (Date rec'd by registrar) C. Dest Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23 1940, at 9:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 15 1940, to 10/23 1940, and that I last saw him alive on 1940.

Immediate cause of death Myocarditis - chronic. Duration: 3 or 4 years. C.W.G.R.

Due to undetermined

Due to an acute attack, 4 or 5 days. Coronary occlusion.

Other conditions "

(Include pregnancy within 3 months of death)

Major findings:

Of operations none

Of autopsy none

DURATION ?1

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide none Date of

Where did injury occur? ✓ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Victor S Miller M. D. or other

Address 131 West Washington St Hagerstown Md. Date signed 10/23-1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 6 1940
BUREAU V. S.

Beat pay Oct 15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

10973

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days.

Hospital, institution, or street address where death occurred: 881 Virginia Ave.

How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 881 Virginia Ave

(If rural, give LOCATION)

2.(a) If veteran, name war no

3. (a) FULL NAME Unnamed Childy Leo Glenn Stottlemeyer

3. (b) Social Security Number none

4. Sex: Male

5. Color or race: white

6.(a) Single, married, widowed, or divorced: Single.

6.(b) Name of husband or wife none

6.(c) If alive, give age none years

7. Birth date of deceased (mo., day, yr.) October ~~14~~ 15 - 1940

8. AGE: Years — Months — Days 2. If less than one day ..... hrs. ..... min.

9. Birthplace Hagerstown Wash Co Md. (Town, county, and state)

10. Usual occupation none

11. Industry or business —

FATHER

12. Name Leo Glenn Stottlemeyer

13. Birthplace Hagerstown Md.

MOTHER

14. Maiden name Hazel Ruth Stottler

15. Birthplace Quincy Pa.

16. Informant Leo Glenn Stottlemeyer

Address Hagerstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 17-1940 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Hagerstown Md.

18. Funeral director Andrew K Coffman

Address Hagerstown Md.

19. October 17 1940 (Date rec'd by registrar) Margaret B. Bowers Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1940, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 14, 1940, to Oct. 16, 1940 and that I last saw him alive on Oct. 16, 1940

Immediate cause of death: Prematurity (6 mos) — DURATION: 2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE [signature] M. D. ~~or other~~

Address Hagerstown Md Date signed 10/17/40

Dr Young

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124a)

10974

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 das.

Hospital, institution, or street address where death occurred: Wash. Co Hospital

How long in hospital or institution? 3 das.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Cearfoss

(If outside city or town limits, write RURAL and give nearest town)

Street No. Dry Run Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war no

3. (a) FULL NAME Harry Paul Stouffer

3. (b) Social Security Number none.

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife Margaret Gillan.

6.(c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) Aug 11-1899.

8. AGE: Years 41 | Months 2 | Days 2. | If less than one day ..... hrs. ..... min.

9. Birthplace Cearfoss Wash. Co Md. (Town, county, and state)

10. Usual occupation Farmer.

11. Industry or business Own Farm.

FATHER

12. Name Martin Stouffer

13. Birthplace Hayetts. Md.

MOTHER

14. Maiden name Ida Spickler.

15. Birthplace Cearfoss Md.

16. Informant Mrs Harry P. Stouffer

Address Cearfoss Md R.F.D.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof Oct 15-1940 (month) (day) (year)

Cemetery or crematory Dunkard Cemetery

Location Broadfording Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown. Md.

19. Oct. 14. 1940 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1940, at 6 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 14 1940, to October 13 1940

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Broncho pneumonia — DURATION: 24 hours

Due to

Due to

Other conditions: Chronic alcoholism

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results Broncho pneumonia - nephritis - hepatitis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE R B Bowers M. D. or other

Address Hagerstown, Md Date signed Oct. 14, 1940

Dr Norment

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

10975

Reg. Diat. No.....

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, Institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 527 W. Franklin Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Samuel H. Strine

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary A. Strine

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 11, 1888

8. AGE: Years	Months	Days	If less than one day
52	0	3	....hrs. ....min.

9. Birthplace York- York County, Pa. (Town, county, and state)

10. Usual occupation Music Instructor

11. Industry or business

FATHER

12. Name Charles J. Strine

13. Birthplace York, Pa.

MOTHER

14. Maiden name Emma Alexander

15. Birthplace York, Pa.

16. Informant Mrs. Mary A. Strine

Address Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof October 17, 1940 (month) (day) (year)

Cemetery or crematory Green Hill Cemetery

Location Martinsburg, W. Va.

18. Funeral director Fred W. Kraiss

Address Hagerstown, Md.

19. October 16 1940 (Date rec'd by registrar) Margaret B. Bowers Registrar

Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14, 1940, 1:50 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 10/7/40, 19..., to 10/14/40, 19..., and that I last saw h... alive on 10/14/40, 19...

Immediate cause of death Cerebral Apoplexy — DURATION 10/7/40

Due to Hypertensive Heart Disease — 3 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. E. Young M. D.

Address Hagerstown Md. M. D. or other Date signed 10/15/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 6 1950
BUREAU V. S.

11067

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(8)

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH:

County Washington

City or town Smithsburg Md #1
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Wash

City or town Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. R. F. D #1 Smithsburg
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Phillis Wolfe

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Single

6.(b) Name of husband or wife none

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 0 Months 0 Days 6 If less than one day ..... hrs. ..... min.

8. Birthplace near Smithsburg R.F.D #1
(Town, county, and state)

10. Usual occupation none

11. Industry or business none

FATHER
12. Name Richard Wolfe
13. Birthplace near Smithsburg Md

MOTHER
14. Maiden name Irene Mangans
15. Birthplace Frederick Co. Md

18. Informant Richard Wolfe
Address Smithsburg Md

17. Burial Date thereof Oct 30-1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Pleasant Valley

Location near Smithsburg Md

18. Funeral director John Bruner
Address Smithsburg

19. Jan 29 1941 Geo. W. Ferguson local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1940, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Still Born	0
Due to	
Due to	
Other conditions	

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo. W. Ferguson Registrar

Address Smithsburg Date signed Oct 29-1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1941
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

10976

Reg. Dist. No. 304

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County WASHINGTON
City or town HANCOCK.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 18 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County WASHINGTON
City or town HANCOCK Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. WARFORDSBURG ROAD
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR NONE.

3. (a) FULL NAME JOHN EZRA. YOUNGBLOOD 3. (b) Social Security Number 131-07-5283

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced MARRIED.

B (b) Name of husband or wife SUSIE V. YOUNG BLOOD. 6(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) MAR 21 1889

8. AGE: Years 51. Months 6 Days 22 If less than one day ____ hrs. ____ min.

9. Birthplace MORGAN CO. W.VA. (Town, county, and state)

10. Usual occupation CARPENTER.

11. Industry or business GENERAL.

FATHER 12. Name CYRUS E. YOUNGBLOOD

13. Birthplace MORGAN CO W.VA.

MOTHER 14. Maiden name NANCY I. DAWSON.

15. Birthplace MORGAN CO W.VA.

16. Informant SUSIE V. YOUNGBLOOD.

Address HANCOCK MD

17. BURIAL. Date thereof 10-15-1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory GREENWAY

Location BERKLEY SPRINGS W.VA.

18. Funeral director J.B. Jenkins

Address Hancock Md

19. 10-14 1940 J.B. Jenkins
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 13. 1940 at 4:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1940 to Oct 13 1940, and that I last saw him alive on Oct 12 1940.

Immediate cause of death — DURATION

Cerebral Hemmorrhage — 48 hrs

Due to Arteriosclerosis plus Hypertension

Due to

Other conditions Diabetes Controlled

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H.E. Fable MD
M. D. or other

Address Hancock, Md Date signed 10/14/40

RECEIVED
NOV 6 1940
BUREAU U. S.